

CRITERIA FOR PRIOR AUTHORIZATION

ADHD Medications – Safe Use for All Ages

PROVIDER GROUP Pharmacy

MANUAL GUIDELINES The following drugs (all strengths and dose forms) require prior authorization as outlined in criteria below:

Amphetamine (Dyanavel XR®)	Guanfacine HCl ER (Intuniv®)
Amphetamine (Adzenys ER®, Adzenys XR-ODT®)	Lisdexamfetamine Dimesylate (Vyvanse®)
Amphetamine/Dextroamphetamine (Adderall®)	Methamphetamine HCl (Desoxyn®)
Amphetamine/Dextroamphetamine (Adderall XR®)	Methylphenidate (Cotempla XR-ODT®)
Amphetamine/Dextroamphetamine (Mydayis®)	Methylphenidate HCl (Aptensio XR®)
Atomoxetine (Strattera®)	Methylphenidate HCl (Concerta®)
Clonidine HCl	Methylphenidate HCl (Metadate CD®)
Clonidine HCl ER (Kapvay®)	Methylphenidate HCl (Metadate ER®)
Dexmethylphenidate HCl (Focalin®)	Methylphenidate HCl (Methylin®)
Dexmethylphenidate HCl ER (Focalin XR®)	Methylphenidate HCl (Quillichew ER)
Dextroamphetamine Sulfate (Zenzedi®)	Methylphenidate HCl (Quillivant XR®)
Dextroamphetamine Sulfate (Dexedrine®)	Methylphenidate HCl (Ritalin®)
Dextroamphetamine Sulfate (DextroStat®)	Methylphenidate HCl (Ritalin LA®)
Dextroamphetamine Sulfate (ProCentra®)	Methylphenidate Transdermal (Daytrana®)
Guanfacine HCl (Tenex®)	

CRITERIA FOR PRIOR AUTHORIZATION FOR ADHD MEDICATIONS:

- PROVIDER TYPE/DIAGNOSIS:
 - Use in **children ≤ 3 years of age**:
 - Must be prescribed by or in consultation/collaboration with a child and adolescent psychiatrist, pediatric neurologist, or developmental-behavioral pediatrician
 - Use in **adults ≥ 18 years of age**:
 - One of the following criteria must be met:
 - Patient must have a documented diagnosis within the previous 365 days of ADHD, binge eating disorder, hyper somnolence, narcolepsy, depression in accordance with DSM-V or cancer related fatigue.
 - OR
 - Prescription must be written by a psychiatrist.
 - Patients with a documented substance abuse diagnosis within the previous 365 days will require a written peer-to-peer consult with health plan psychiatrist, medical director, or pharmacy director for approval, followed by a verbal peer-to-peer, if unable to approve written request.
- DOSING LIMITS:
 - Doses exceeding those listed in Table 1 will require a prior authorization
 - Prior authorization will require a written peer-to-peer consult with health plan psychiatrist, medical director, or pharmacy director for approval, followed by a verbal peer-to-peer, if unable to approve written request.

LENGTH OF APPROVAL: 12 months

RENEWAL CRITERIA: Patient is stable and has been seen in the past year.

APPROVED PA Criteria

TABLE 1: ADHD MEDICATION DOSING LIMITS

Drug	Maximum Daily Dose
Amphetamine (Dyanavel®)	20mg
Amphetamine (Adzenys ER®, Adzenys XR-ODT®)	18.8 mg
Amphetamine/Dextroamphetamine (Adderall®)	60mg
Amphetamine/Dextroamphetamine (Adderall XR)	60mg
Amphetamine/Dextroamphetamine (Mydayis®)	50 mg
Atomoxetine (Strattera®)	100mg
Clonidine HCl	0.4mg
Clonidine HCl ER (Kapvay®)	0.4mg
Dexmethylphenidate HCl ER (Focalin XR®)	50mg
Dexmethylphenidate HCl (Focalin®)	20mg
Dextroamphetamine Sulfate (Dexedrine®, DextroStat®, ProCentra®, Zenzedi®)	60mg
Guanfacine HCl (Tenex®)	4mg
Guanfacine HCl ER (Intuniv®)	7mg
Lisdexamfetamine Dimesylate (Vyvanse®)	70mg
Methamphetamine HCl (Desoxyn®)	25mg
Methylphenidate (Cotempla XR-ODT®)	51.8 mg
Methylphenidate HCl (Methylin®, Ritalin®)	100mg
Methylphenidate HCl ER (Aptensio XR®, Metadate CD®, Metadate ER®, QuilliChew ER, Quillivant XR®, Ritalin LA®)	100mg
Methylphenidate HCl ER (Concerta®)	108mg
Methylphenidate Transdermal (Daytrana®)	30mg/9hr/day

DRUG UTILIZATION REVIEW COMMITTEE CHAIR

PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

DATE

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